Weight Management & Bariatric Surgery Clinical Focus Group

Digestive Health Institute

Robert Quinton, Portland, OR

Philippe Quilici, MD, Burbank, CA

February 24, 2016

Weight Management/Bariatric Surgery CFG

Region	Name	Title
AK	Amy Myers	Director of Digestive Health
CA	Eric Becker	Providence Partners for Health Manager
CA	Rosanne Morrison	Regional Director Women/Childrens
CA	Philippe Quilici MD	Program Director Weight Loss/Bariatric Surgery
MT	Bradley Pickhardt MD	Program Director Weight Loss/Bariatric Surgery
NW WA	Alana Chock MD	Medical Director
NW WA	Mitesh Parikh	Vice President, Service Line Development
NW WA	Joanne Roberts MD	Chief Medical Officer, Liaison to Clinical Council
OR	Chet Hammill MD	General Surgeon
OR	Robert Quinton	Executive Surgery Program
OR	Kevin Reavis MD	Surgeon, Gastroenterology and Minimally Invasive Surgery
PHC WA	Chris Bowler	Value Analysis Program Coordinator
PHC WA	Barb Reinhardt RN	Senior Director, Physician Practice
SW WA	Kasia Konieczny	Director, Oncology Service Line; Director Digestive Health
WWR WA	Marc Horton MD	Executive Medical Director
WWR WA	Spenser Troiano	Senior Business Development Specialist
Analytics	Heather Cook	Senior Healthcare Intelligence Analyst
Analytics	Troy Hanninen	Clinical Business Intelligence Analyst
Finance	Geoffrey Martin	Financial Analysis Manager, Finance And Compensation
Health Plan	David Pass MD	Medical Director, Quality Providence Health Plan
Marketing	Fina Araya	Senior Product Manager, Marketing
Payor Contracting	Michele Anderson	Director of Regional Contracts
Primary Care	Jon Younger MD	Vice-President Primary Care
Supply Chain	Jimmy Chung MD	Director, Medical Products Analysis
Value Analysis	Mike Horrigan	Program Manager Clinical Value Analysis

Agenda

Time	Topic	Speaker
0700am	Welcome/Roll Call	Nicole Bahr
0705am	Background & Digestive Institute Goals	Lynda Baxter
0715am	CFG priorities and initial inventory feedback	Dr Philippe Quilici Robert Quinton
0740am	DRAFT analytics – beginning to tell our story	Lynda Baxter Troy Hanninen
0755am	Timeline & Next Steps	Lynda Baxter
8am	**Adjourn**	

Clinical Program Services: Background and Past Successes

Providence has achieved substantial system-wide improvements over the past several years.

- Providence worked to improve expert collaboration, better organize research and improve clinical standardization and innovation.
- This has been an effort to improve the quality and efficiency of the care that Providence provides.

This led to many successes:

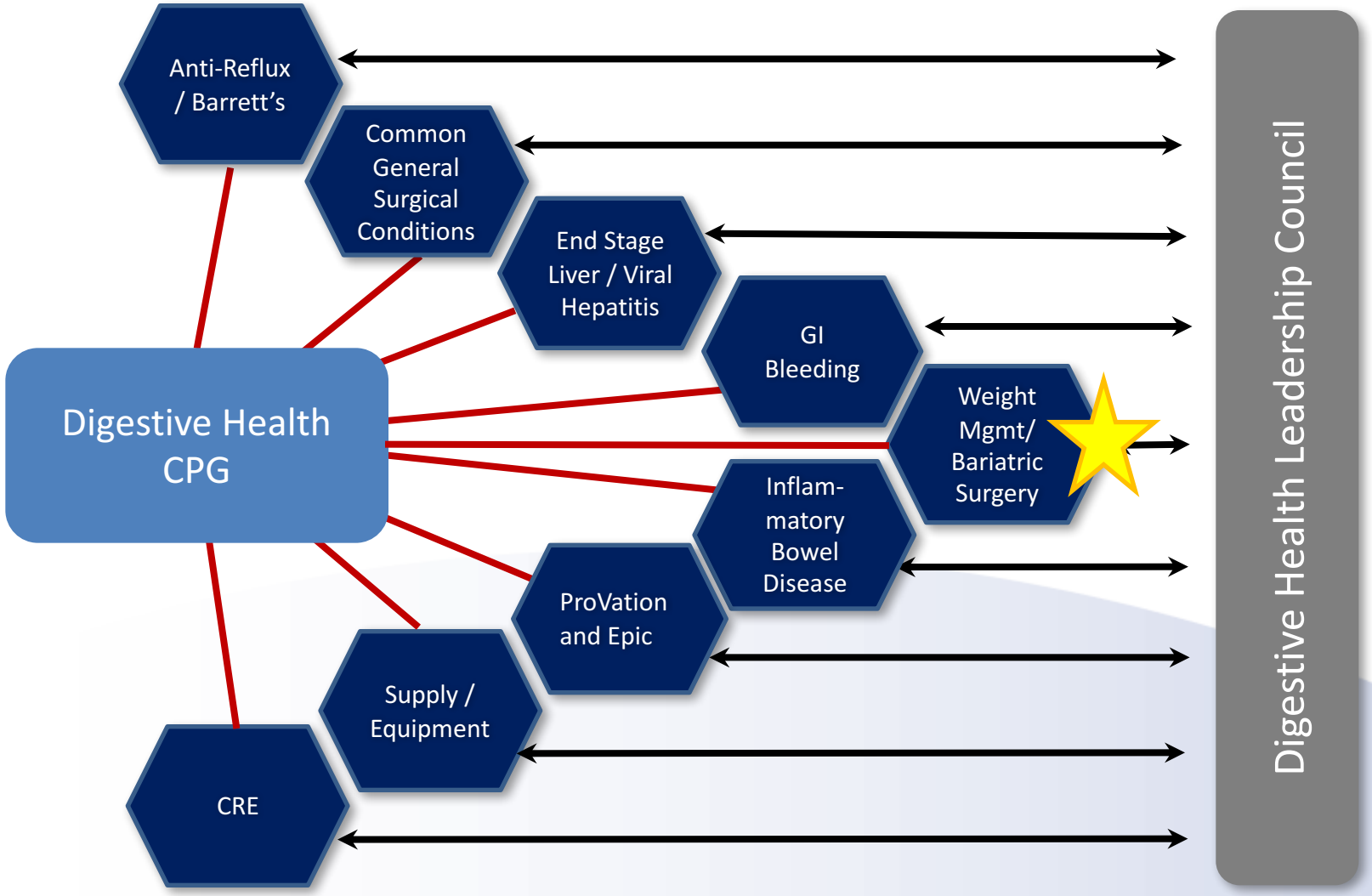
Better organized research across the enterprise	Clinical best practices were shared at hundreds of forums
Better standardization	34 system-wide registries implemented
Thousands of clinicians have been involved	**$100m** in savings achieved

6 clinical priorities determined:

Cancer
Cardiovascular
Digestive Health
Musculoskeletal
Neurosciences
Women's & Children's

Digestive Health Clinical Performance Group Collaboration

The work of the Digestive Health Leadership Council will foster collaboration around clinical expertise, strategy, and business planning. The Digestive Health Focus Groups will remain a key resource for clinical best practice and direction.



Focus Group Responsibilities

- Represent your peers in this critical transformational work
- Set the strategic direction for the focus group
- Be the clinical expert panel for formulary, major purchasing decision making and Epic improvements
- Identify opportunities for program efficiencies, prevention and population health
- Evaluate new products through a clinical perspective incorporating financial models to secure a comprehensive value assessment
- Identify meaningful opportunities in research and innovation and the complementary data needs
- Assist with the development of new reimbursement models

Support team

- CPS Sr Director
- CPS Sr Project Mgr and Prg Mgr
- Health Care Intelligence analysts
- Finance / Decision Support analysts
- Marketing
- Value Analysis / Supply Chain
- Others as needed

Future success depends on the successful implementation of the Institutes model

Clinical Institutes will improve care quality, attract patients and drive the success and sustainability of our organization.

The Institutes model will help solve these problems

To succeed and grow we need to:

- guarantee quality
- guarantee predictable costs
- provide a smooth and positive patient experience
- deliver excellent care across our entire system

Improved ability to coordinate care across practitioners and sites

Enhanced partnerships between primary providers and specialists

Harnessing the power of the entire west coast

Clinical Institutes

CARE DELIVERY	Connected, virtual, integrated, streamlined
PATIENT EXPERIENCE	Easy access, predictable costs & outcomes
PHYSICIAN PERCEPTION	Data shows that we provide the best care
BRAND	Brand recognized for excellent care
RESEARCH	Excellent research, cutting edge treatments
RESOURCES	System-wide view of resource allocation
MEASUREMENT	Standardized measurement of performance

Quality

Optimization

Phase 1 Digestive Health Institute – Pilot Network, Weight Management

Initial Weight Management efforts will be focused at ensuring high quality bariatric surgical care and improved coordination and referral capture between Providence regions to drive additional bariatric surgery volume to Centers of Focused Expertise.

- Currently, two of the five Providence bariatric surgery centers have accredited programs:
  - Providence Saint Joseph Medical Center, Burbank CA
  - Swedish Medical Center, Seattle WA
- Institute efforts to develop the Providence bariatric surgery network will initially focus on:
  - Coordination with Providence facilities providing pre and post-bariatric surgical services and ensuring high performance/high quality, at the best cost, at all surgical sites.
  - Identifying future locations for additional Centers of Focused Expertise / accredited programs.
  - Additional investments may include building new weight management & bariatric surgery programs in regions where demand justifies it
  - Evaluation of PHS and ACO pilots of OMADA/Prevent for weight loss, behavioral medicine & diabetes prevention.
- Develop insurer contract strategy to be network of choice:
  - Not all employers offer bariatric surgery as a covered benefit for members.
  - Most insurers require facilities to be accredited for inclusion as an approved bariatric surgery center.
  - Bariatric surgery programs are accredited based on standards jointly developed by the American College of Surgeons and the American Society for Metabolic and the Bariatric Surgery.

MBSAQIP
METABOLIC AND BARIATRIC SURGERY ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

Weight Management/Bariatric Surgery CFG

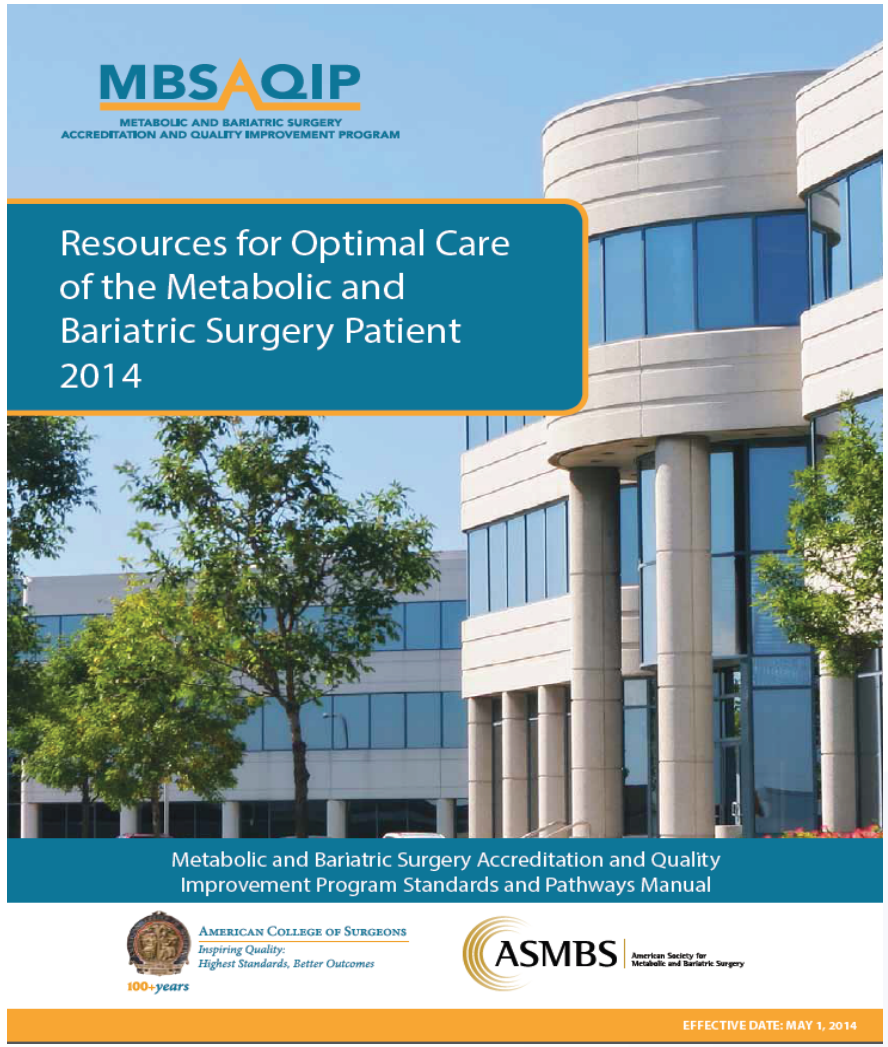
Initial focus areas and alignment efforts

- Focus areas
  - Define min specs of weight management program
  - Gap analysis of existing services/capabilities
  - Recommend quality standards & clinical outcomes
  - Develop and implement evidence based protocols/pathways
  - Define COE* requirements by payor group
  - Create marketing tool kit & pilot at key sites
  - Analytics, registry and dashboard development

- Alignment efforts
  - Women & Children's CPG (Wellness CFG)
  - Primary Care- Ambulatory Clinical Council

*COE- Center of Excellence

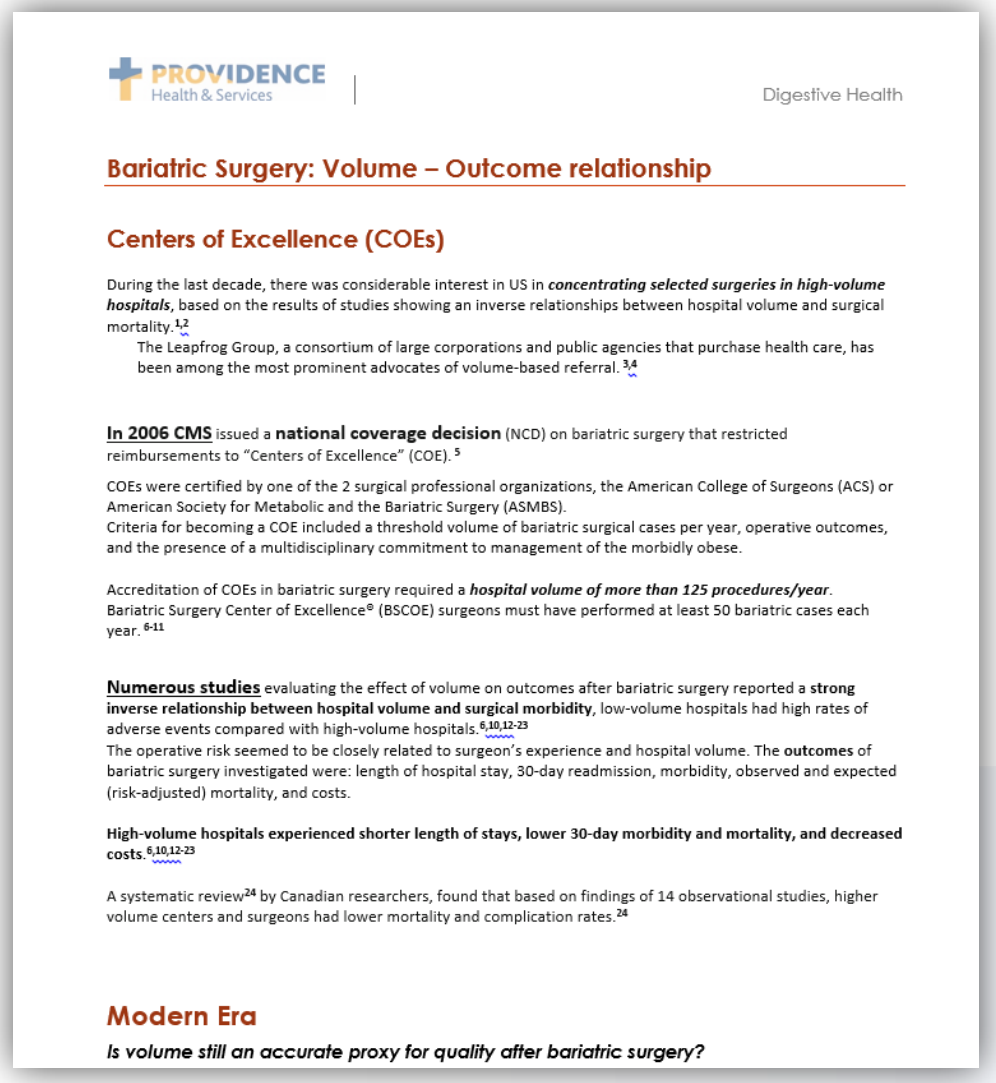
Initial Inventory Feedback



Access manual here

- Define min specs of weight management program and conduct gap analysis
  - Leverage SRC or MBSAQIP COE requirements
  - Include surgical and non-surgical i.e. education, exercise, nutrition, behavioral medicine, PT, etc.
  - Define by setting: community, tertiary, quaternary services
  - Include equipment and facility requirements
  - Potential Program Model: LA Cedars Sinai Weight Management Program

Initial Inventory Feedback continued.



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Bariatric Surgery: Volume – Outcome relationship

Centers of Excellence (COEs)

During the last decade, there was considerable interest in US in ***concentrating selected surgeries in high-volume hospitals***, based on the results of studies showing an inverse relationships between hospital volume and surgical mortality.[1,2]

The Leapfrog Group, a consortium of large corporations and public agencies that purchase health care, has been among the most prominent advocates of volume-based referral.[3,4]

In 2006 CMS issued a **national coverage decision** (NCD) on bariatric surgery that restricted reimbursements to "Centers of Excellence" (COE).[5]

COEs were certified by one of the 2 surgical professional organizations, the American College of Surgeons (ACS) or American Society for Metabolic and the Bariatric Surgery (ASMBS).
Criteria for becoming a COE included a threshold volume of bariatric surgical cases per year, operative outcomes, and the presence of a multidisciplinary commitment to management of the morbidly obese.

Accreditation of COEs in bariatric surgery required a ***hospital volume of more than 125 procedures/year***.
Bariatric Surgery Center of Excellence® (BSCOE) surgeons must have performed at least 50 bariatric cases each year.[6-11]

Numerous studies evaluating the effect of volume on outcomes after bariatric surgery reported a **strong inverse relationship between hospital volume and surgical morbidity**, low-volume hospitals had high rates of adverse events compared with high-volume hospitals.[6,10,12-23]
The operative risk seemed to be closely related to surgeon's experience and hospital volume. The **outcomes** of bariatric surgery investigated were: length of hospital stay, 30-day readmission, morbidity, observed and expected (risk-adjusted) mortality, and costs.

High-volume hospitals experienced shorter length of stays, lower 30-day morbidity and mortality, and decreased costs.[6,10,12-23]

A systematic review[24] by Canadian researchers, found that based on findings of 14 observational studies, higher volume centers and surgeons had lower mortality and complication rates.[24]

Modern Era

Is volume still an accurate proxy for quality after bariatric surgery?

Access the full research paper here

- Recommend quality standards & clinical outcomes
  - By procedure type (Laparoscopic Sleeve Gastrectomy, Laparoscopic Roux-en-Y Gastric Bypass, Laparoscopic Adjustable Gastric Band) including new techniques (gastric ballon)
  - Include adult and adolescent populations
  - Align w/criteria needed to achieve MBSAQIP and payor COE status
  - Review research on evidence based standards

Initial Inventory Feedback continued

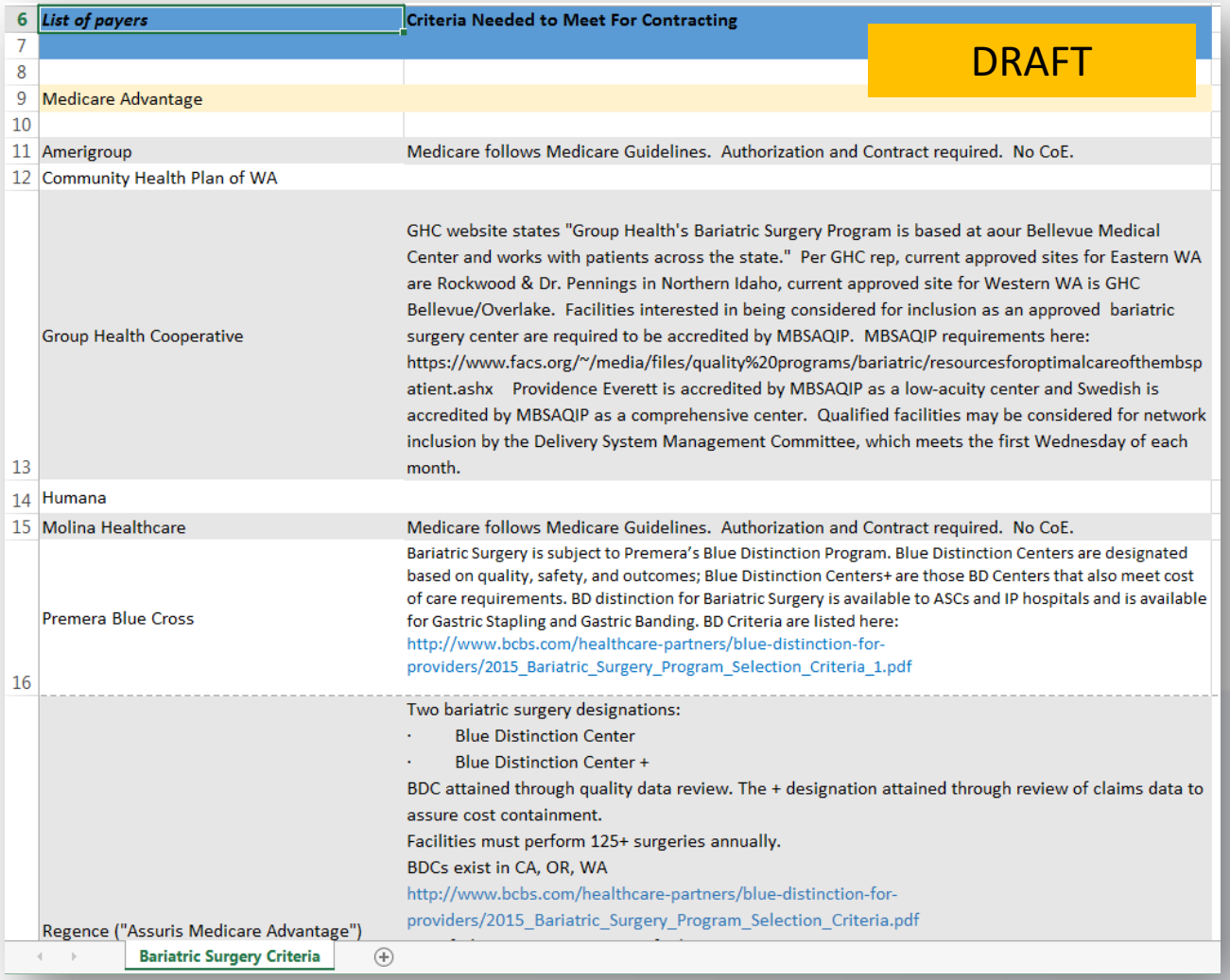
Care pathway - Anesthesia and Airway Management

Point of Care	Pathway	Expected Outcome	Reference
Initial Visit	Airway assessment including history of OSA, asthma, and Obesity Hypoventilation Syndrome. OSA Screening performed. Neck circumference done	Any undiagnosed potential airway management problems identified	STOP-Bang tool Individual patient record
2nd medical visit	Review of ABG results, if ordered	If abnormal, plan of care and referrals are made as necessary. Most common referrals are Pulmonary Function and Sleep Medicine.	
History and Physical	Examination of lung function: auscultation, O2 saturation.	No abnormal lung function detected	
Pre-Admit call, RN apt. if required	Nursing assessment: O2 sat, review of history of anesthesia complications. Consultation with anesthesia if needed	Safe passage through the peri-operative period without airway compromise	
Pre-operative staging area – visit from anesthesiologist	Anesthesia assessment of airway and anesthesia risk. Directed history and physical exam	Safe passage through the peri-operative period without airway compromise	Individual patient record. Mallampati Score used to assess airway. ASA score assigned
Intraoperative care	Anesthesiologist administers medication and maintains airway. Specialized airway management equipment available. Bronchodilator medication used if needed. Each patient's risk is evaluated. Long acting medications are avoided to allow	Safe passage through the peri-operative period without airway compromise	See individual patient record of assessment and interaoperative anesthesia care.

Access protocol here

- Evidenced based pathways/protocols (short list)
  - MBSAQIP requires clinical protocol development- opportunity to standardize on evidence based practice
  - Anesthesia, including monitoring and airway management
  - Perioperative care, including monitoring, pain management and airway management
  - Deep vein thrombosis (DVT) prevention
  - Identification and evaluation of early warning signs of complications
  - Nutrition, specified diets
  - Enhanced Recovery After Surgery (ERAS)

Initial Inventory Feedback continued



	List of payers	Criteria Needed to Meet For Contracting
6		
7		
8		
9	Medicare Advantage	
10		
11	Amerigroup	Medicare follows Medicare Guidelines. Authorization and Contract required. No CoE.
12	Community Health Plan of WA	
13	Group Health Cooperative	GHC website states "Group Health's Bariatric Surgery Program is based at aour Bellevue Medical Center and works with patients across the state." Per GHC rep, current approved sites for Eastern WA are Rockwood & Dr. Pennings in Northern Idaho, current approved site for Western WA is GHC Bellevue/Overlake. Facilities interested in being considered for inclusion as an approved bariatric surgery center are required to be accredited by MBSAQIP. MBSAQIP requirements here: https://www.facs.org/~/media/files/quality%20programs/bariatric/resourcesforoptimalcareofthembspatient.ashx Providence Everett is accredited by MBSAQIP as a low-acuity center and Swedish is accredited by MBSAQIP as a comprehensive center. Qualified facilities may be considered for network inclusion by the Delivery System Management Committee, which meets the first Wednesday of each month.
14	Humana	
15	Molina Healthcare	Medicare follows Medicare Guidelines. Authorization and Contract required. No CoE.
16	Premera Blue Cross	Bariatric Surgery is subject to Premera's Blue Distinction Program. Blue Distinction Centers are designated based on quality, safety, and outcomes; Blue Distinction Centers+ are those BD Centers that also meet cost of care requirements. BD distinction for Bariatric Surgery is available to ASCs and IP hospitals and is available for Gastric Stapling and Gastric Banding. BD Criteria are listed here: http://www.bcbs.com/healthcare-partners/blue-distinction-for-providers/2015_Bariatric_Surgery_Program_Selection_Criteria_1.pdf
	Regence ("Assuris Medicare Advantage")	Two bariatric surgery designations: · Blue Distinction Center · Blue Distinction Center + BDC attained through quality data review. The + designation attained through review of claims data to assure cost containment. Facilities must perform 125+ surgeries annually. BDCs exist in CA, OR, WA http://www.bcbs.com/healthcare-partners/blue-distinction-for-providers/2015_Bariatric_Surgery_Program_Selection_Criteria.pdf

Bariatric Surgery Criteria

DRAFT

Access inventory here

Payor COE requirements for contracting

- Some require MBSAQIP COE requirements for contracting
  - AETNA (3 STAR program)
  - Group Health Cooperative
- Others have their own criteria
  - Premera's Blue Distinction Program (125+ surgeries annually)
  - Medicaid Apple Health- must use state-approved COE. Requirements: 1) Program history of more than 100 bariatric procedures; 2) Program in operation more than 5 years; 3) Program mortality rate of 2% or less; 4) Program morbidity rate of 15% or less; 5) Document patient follow up for at least 5 years postsurgery; 6) Average loss of at least 50% of excess body weight at 5 years postsurgery;

Initial Inventory Feedback continued

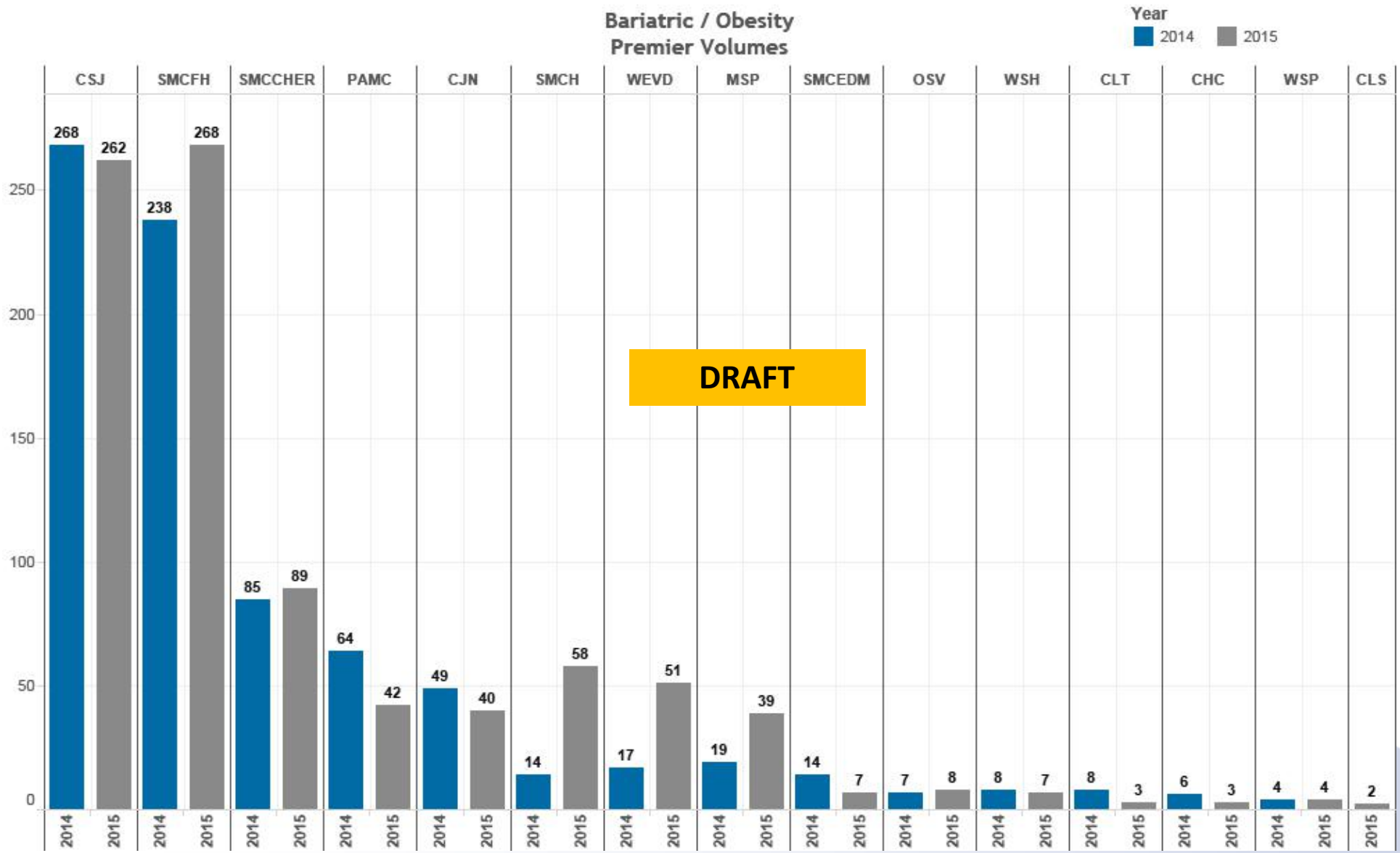
Population Definitions

- MSDRG
  - 619 - O.R. PROCEDURES FOR OBESITY W MCC
  - 620 - O.R. PROCEDURES FOR OBESITY W CC
  - 621 - O.R. PROCEDURES FOR OBESITY W/O CC/MCC
- Source
  - Premier

Slides 16-21
Example analytics to be vetted by this team

- Analytics, registry and dashboard development
  - Accrediting bodies require data submission for compliance
  - Some sites have robust analytics; others need abstraction support
  - Epic tools for PCP referrals to weight loss programs
  - What other data is important to track & benchmark i.e. complication rates (pulmonary, wound infection, Hemorrhage), cost, weight loss after 1 yr, % resolved type 2 diabetes, etc.
  - Are there related metrics on other dashboards across the system i.e. BMI w/primary care?

Bariatric IP 2014-2015



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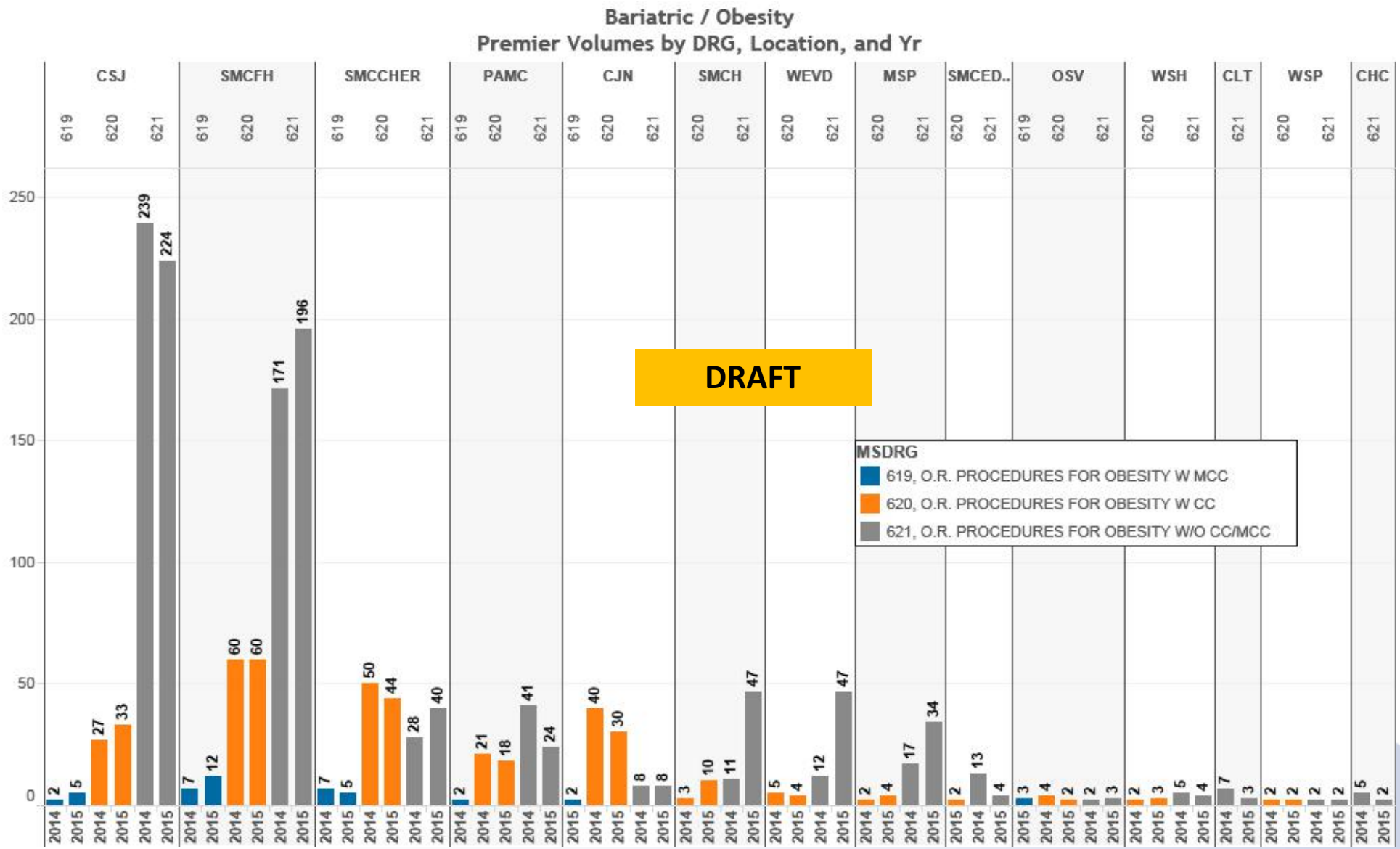

Bariatric IP 2014-2015

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Bariatric / Obesity Primary Payers

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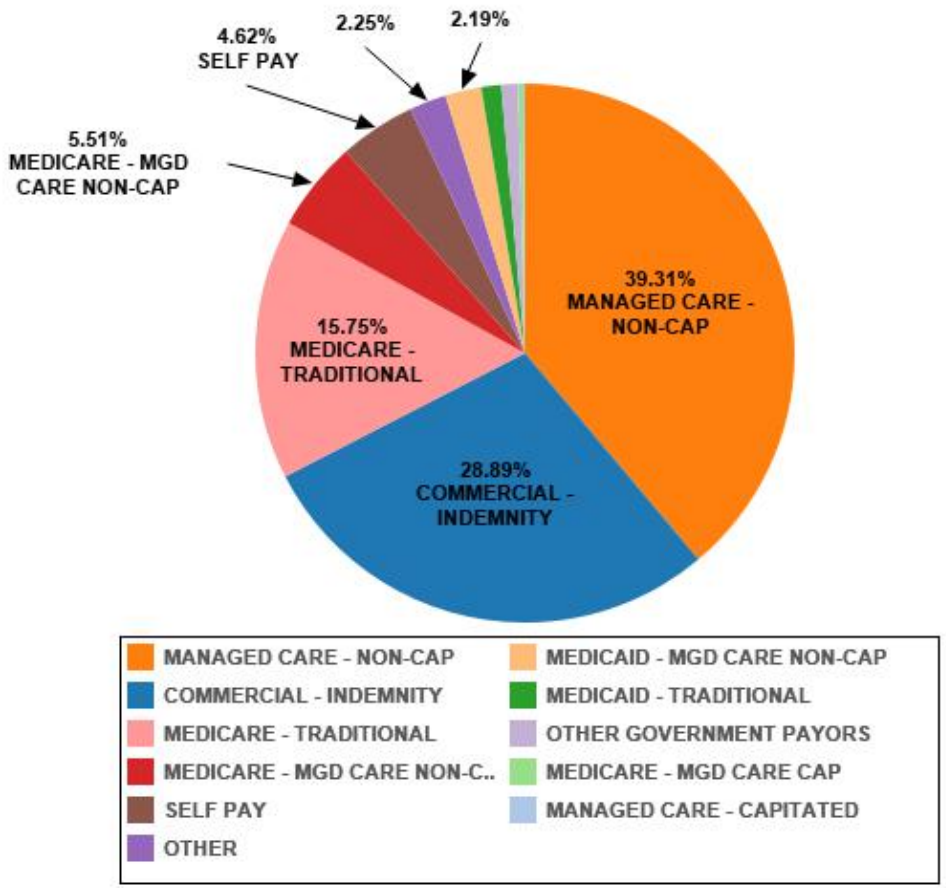

Bariatric / Obesity Regional Volumes

Region	YEAR	COUNT	% Change	% Commercial Payers
AK	2014	64	0.0%	67.2%
	2015	42	-34.4%	69.0%
CA	2014	333	0.0%	82.9%
	2015	310	-6.9%	77.7%
NWR	2014	17	0.0%	94.1%
	2015	51	200.0%	100.0%
OR	2014	7	0.0%	71.4%
	2015	10	42.9%	70.0%
PHC	2014	8	0.0%	50.0%
	2015	7	-12.5%	42.9%
SER	2014	1	0.0%	0.0%
SWED	2014	351	0.0%	53.3%
	2015	422	20.2%	59.5%
SWR	2014	4	0.0%	25.0%
	2015	4	0.0%	25.0%
WMR	2014	19	0.0%	57.9%
	2015	39	105.3%	48.7%

Commercial = 'MANAGED CARE - NON-CAP' & 'COMMERCIAL INDEMNITY'

Bariatric IP 2014-2015

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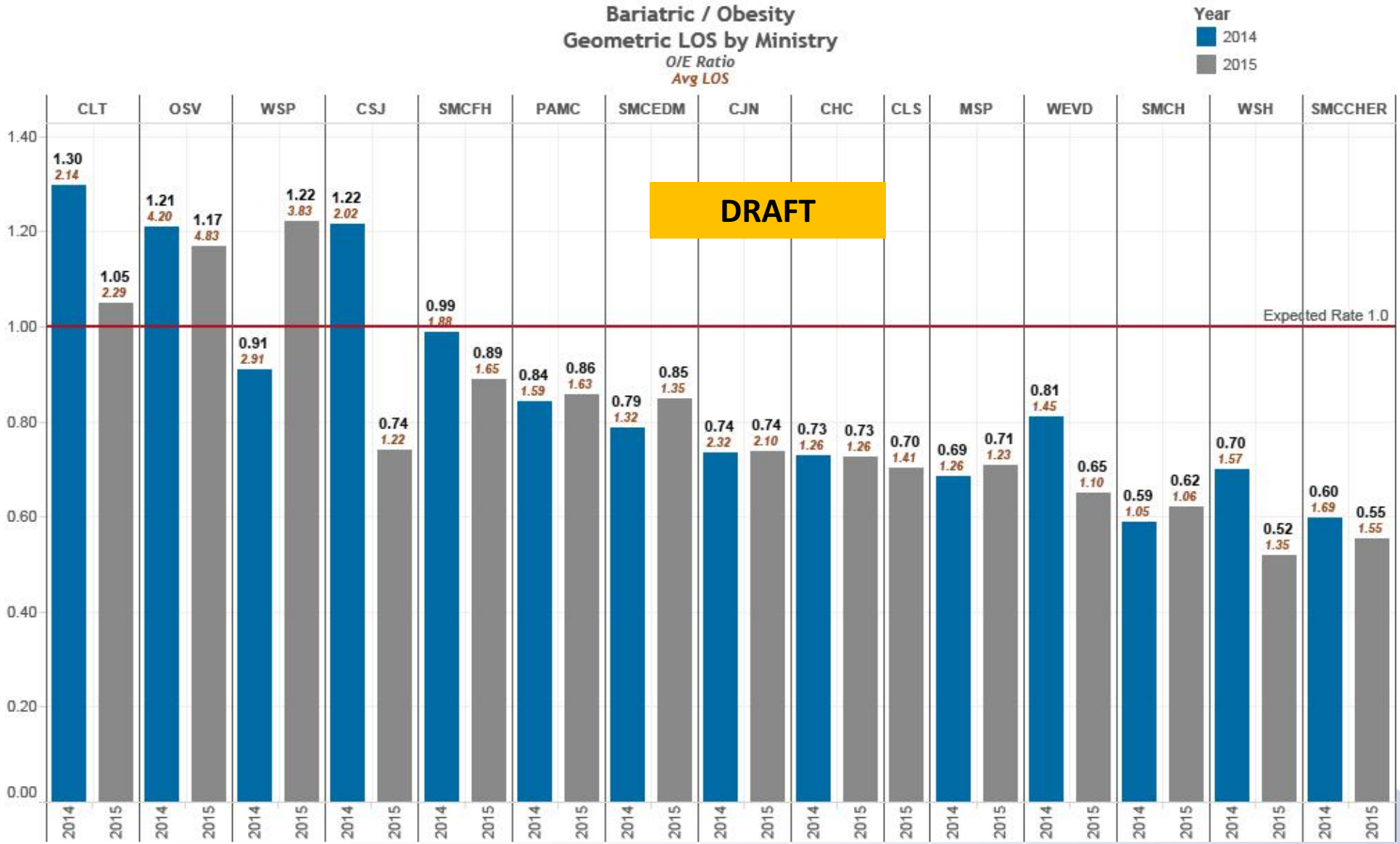
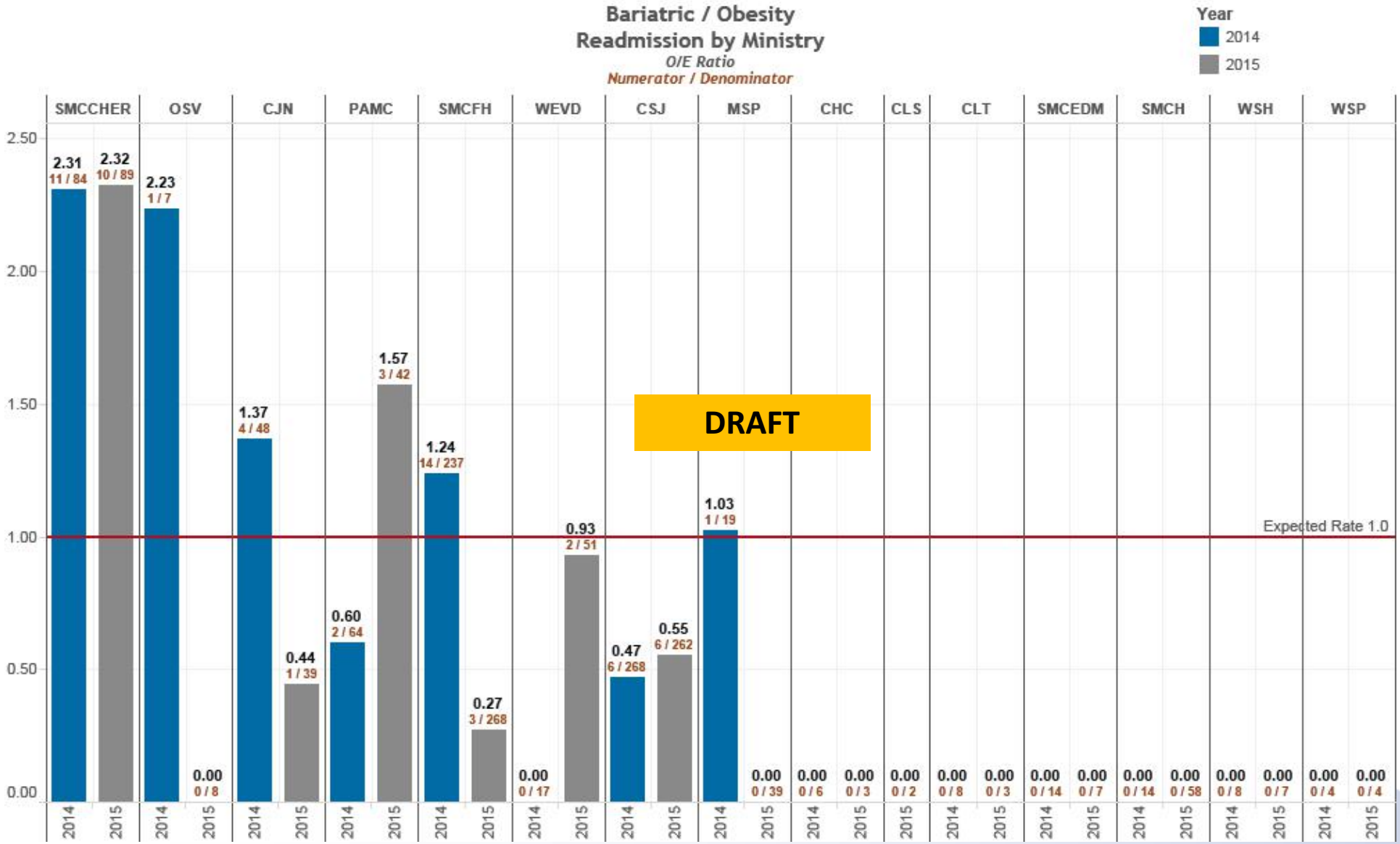


Bariatric IP 2014-2015



Weight Management / Bariatric Surgery Roadmap 2016-2017

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Priority	Q1 2016			Q2 2016			Q3 2016			Q4 2016			Q1 2017			Q2 2017		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
System minimum spec WM program • Define min spec • Conduct gap analysis • Finalize and approve min spec • MBSAQIP requirements/costs • Site readiness for application									DH Summit 9/15 &16									
System dashboard development • Define clinical and financial metrics • Baseline data capture • Set improvement targets • Develop reporting and feedback tools • Dashboards by site							Score card developed											
Predictable clinical excellence and cost • Evidence base pathway development • Resource optimization opportunities																		
COE and Contract Requirements • Define payor contract requirements local and national • Develop strategy to be network of choice																		
Pathway pilot launch & monitor • Assess learnings & update protocol • Identify other sites and implement other protocols																		
Epic Optimization • Automate Pathway • Optimize Order Sets													Swedish Epic tools Providence Epic tools					

Next Steps

- Save the date- Thursday April 28 in person meeting Burbank CA
- Develop program min spec template & begin gap analysis
- Define key metrics and determine registry needs
- Clinical SMEs to assist w/data analytics
- Gather existing protocols and prioritize development
- Request access to WM Bariatric WellSpot
  - https://www.wellspot.org/groups/weight-management-bariatric-cpg
  - Upload your best practices, tools, protocols, research, etc
- Next conference call- Wednesday March 23